PROVIDER NUMBER
0

SCHEDULE F BEGINNING & ENDING RESIDUAL BALANCES RECONCILIATION

BALANCE AT BEGINNING OF PERIOD - LINE 377, 378, & 379, COLUMN 2	401		$0
INCREASES:			
REVENUE PER LINE 449, COLUMN 1	402	$0	
INVESTMENT BY OWNER	403	$0	
TRANSFERS FROM CENTRAL OFFICE	404	$0	
COMMON STOCK SOLD	405	$0	
OTHER (SPECIFY)	406	$0	
OTHER (SPECIFY)	407	$0	
TOTAL INCREASES	408		$0
DECREASES:			
EXPENSES PER SCHEDULE A, LINE 215, COLUMN 2	411	$0	
WITHDRAWAL BY OWNERS NOT IN SCHEDULE A	412	$0	
TRANSFERS TO CENTRAL OFFICE	413	$0	
DIVIDENDS PAID TO STOCKHOLDERS	414	$0	
DEPRECIATION EXPENSE IN EXCESS OF STRAIGHT LINE	415	$0	
OTHER (SPECIFY)	416	$0	
OTHER (SPECIFY)	417	$0	
TOTAL DECREASES	418		$0
BALANCE AT END OF PERIOD - LINE 377, 378, & 379, COLUMN 4	419		$0

PROVIDER NUMBER
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ULE G REVENUE STATEMENT

	LN#	REV PER BOOKS OR FED TAX RETURN (1)	ADJUSTMENT TO EXPENSE ACCOUNTS (2)	LINE NUMBER OF RELATED EXPENSE (3)
)UTINE DAILY SERVICE:				
PRIVATE PAY RESIDENTS	431	$0	$0	
MEDICAID RESIDENTS & PATIENT LIABILITY	432	$0	$0	
MEDICARE RESIDENTS (PART A)	433	$0	$0	
VETERAN ADMINISTRATION RESIDENTS	434	$0	$0	
OTHER RESIDENTS (SPECIFY)	435	$0	$0	
HARMACY - DRUGS & MEDICATIONS	436	$0	$0	
:OUTINE NURSING SUPPLIES SOLD TO PRIVATE PAY RESIDENTS	437	$0	$0	
:EVENUE FROM MEALS SOLD TO GUESTS & EMPLOYEES	438	$0	$0	
3E/ 'BARBER SHOP	439	$0	$0	
:ESIDENT PURCHASES/NON ROUTINE ITEMS SOLD	440	$0	$0	
'URCHASE DISCOUNTS, RETURNS & ALLOWANCES	441	$0	$0	
)THER SUPPLIES SOLD	442	$0	$0	
'ROGRAM REIMBURSEMENTS & TAX CREDITS	443	$0	$0	
INVESTMENT/INTEREST INCOME	444	$0	$0	
VENDING MACHINE REVENUE	445	$0	$0	
DAY CARE/TREATMENT INCOME	446	$0	$0	
MEDICARE PART B	447	$0	$0	
OTHER (SPECIFY)	448	$0	$0	
TOTALS	449	$0	$0	

PROVIDER NUMBER
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HEDULE H STATEMENT OF RELATED ADULT CARE HOME INFORMATION

461 DO ANY OF THE OWNERS, RELATED PARTIES OR EMPLOYEES HAVE INTEREST, DIRECTLY OR INDIRECTLY, IN ANY OTHER ADULT CARE HOME FACILITY LOCATED IN KANSAS (EXCEPT MINOR STOCK OWNERSHIP AS A PASSIVE INVESTMENT IN UNRELATED PUBLICLY HELD CORPORATION? ☐ YES ☐ NO

IF YOUR ANSWER IS NO, DO NOT COMPLETE THE REST OF THIS SCHEDULE, BUT GO TO SCHEDULE I. IF YOUR ANSWER IS YES, LIST BELOW ALL ADULT CARE HOME FACILITIES LOCATED IN KANSAS IN WHICH AN INTEREST EXISTS OR THAT ARE UNDER COMMON CONTROL OR OWNERSHIP. ATTACH SCHEDULE IF NECESSARY.

	(1) RELATED PROVIDER'S NAME	(2) MEDICAID PROVIDER #	(3) DESCRIBE RELATIONSHIP: OWNERSHIP/MANAGEMENT/DIRECTORS
465			
466			
467			
468			
469			
470			
471			
472			
473			
474			
475			
476			
477			
478			
479			
480			

IF PROVIDER IS A CORPORATION, IS IT A PUBLICLY HELD CORPORATION? ☐ YES ☐ NO
IF YES, ATTACH A COPY OF THE ANNUAL REPORT TO STOCKHOLDERS AND A FORM 10-K.

PROVIDER NUMBER
0

SC. .JULE I FIXED ASSET, DEPRECIATION & AMORTIZATION QUESTIONNAIRE

481	DOES THE PROVIDER LEASE OR RENT ANY PART OF THE PHYSICAL FACILITY FROM ANY OTHER ENTITY?.....	☐ YES	☐ NO
482	IF YES, DO ANY OWNERS OF THE PHYSICAL FACILITY HAVE AN INTEREST, DIRECTLY OR INDIRECTLY, IN THE PROVIDER?.....	☐ YES	☐ NO

IF YES, PROVIDE THE OWNERSHIP INFORMATION REQUESTED BELOW. IF NO, GO TO QUESTION 493.

	NAME OF OWNERS OF PHYSICAL FACILITY	% OF OWNERSHIP	DESCRIBE NATURE OF RELATIONSHIP WITH PROVIDER. IF NONE, WRITE "NONE"
485			
486			
487			
488			
489			

IF THE OWNERS ARE OTHER THAN INDIVIDUALS, READ AND FOLLOW THE INSTRUCTIONS FOR LINES 482-489 FOR COMPLEX CAPITAL STRUCTURES.

491	HAVE COPIES OF ALL LEASE AGREEMENTS (INCLUDING AMENDMENTS) BEEN SUBMITTED WITH A PREVIOUS COST REPORT? ..... **IF NO, SUBMIT COPIES OF DOCUMENTS NOT PREVIOUSLY SUBMITTED**	☐ YES	☐ NO
492	DOES THE LEASE CONTAIN AN OPTION TO PURCHASE THE LEASED PROPERTY?	☐ YES	☐ NO
493	IS THE PHYSICAL FACILITY OWNED BY THE PROVIDER?	☐ YES	☐ NO
494	IF OWNED, WAS THE PURCHASE AN ARMS LENGTH TRANSACTION?..... (ATTACH A STATEMENT OUTLINING DETAILS OF THE PURCHASE)	☐ YES	☐ NO
495	WAS THE STRAIGHT LINE DEPRECIATION METHOD USED?.....	☐ YES	☐ NO
	IF NO, HAVE YOU RECALCULATED THE DEPRECIATION USING THE STRAIGHT LINE METHOD AND MADE THE APPROPRIATE ADJUSTMENTS TO THE DEPRECIATION EXPENSE REPORTED ON THE EXPENSE STATEMENT?	☐ YES	☐ NO
496	DID YOU ATTACH A DETAILED DEPRECIATION SCHEDULE & WORKING TRIAL BALANCE TO THIS COST REPORT?..... **IF NO, SUBMIT COPIES OF DOCUMENT NOW**	☐ YES	☐ NO

PROVIDER NUMBER
0

3(JLE J **EMPLOYEE TURNOVER REPORT**

LN#	SALARY CLASSIFICATION	(2) BEGINNING # OF EMPLOYEES	(3) EMPLOYEES HIRED	(4) EMPLOYEES TERMINATED	(5) ENDING # OF EMPLOYEES	(6) HOW MANY FROM (5) ARE: FULL-TIME	(6) HOW MANY FROM (5) ARE: PART-TIME
497	ADMINISTRATOR	0	0	0	0		
498	CO-ADMINISTRATOR	0	0	0	0		
499	OTHER ADMINISTRATIVE	0	0	0	0		
500	PLANT OPERATING	0	0	0	0		
501	DIETARY	0	0	0	0		
502	LAUNDRY	0	0	0	0		
503	HOUSEKEEPING	0	0	0	0		
504	REGISTERED NURSES	0	0	0	0		
505	LPN	0	0	0	0		
506	LICENSED M/H TECH	0	0	0	0		
507	AIDES	0	0	0	0		
508	PHYSICAL THERAPIST	0	0	0	0		
509	SPEECH THERAPIST	0	0	0	0		
510	OCCUPATIONAL THERAPIST	0	0	0	0		
511	RESPIRATORY THERAPIST	0	0	0	0		
512	PSYCH THERAPIST	0	0	0	0		
513	RECREATION THERAPIST	0	0	0	0		
5	ESIDENT ACTIVITY	0	0	0	0		
51	OCIAL WORKER	0	0	0	0		
516	MEDICAL RECORDS	0	0	0	0		
517	OTHER HEALTH CARE	0	0	0	0		
518	TOTAL ALL CLASSIFICATION	0	0	0	0	0	0

ATTENTION

COMPLETE THE COST REPORT ACCORDING TO THE INSTRUCTIONS AND ATTACH REQUIRED DOCUMENTS.

1. HAS THE REPORT BEEN SIGNED BY THE OWNER/AUTHORIZED AGENT AND THE PREPARER?
2. ARE ALL COST REPORT SCHEDULES COMPLETE?
3. ARE TWO (2) COPIES OF THE COMPLETED COST REPORT AND ONE COPY OF THE AU-3902 (CENSUS DISKETTE SHEET) BEING SUBMITTED?
4. ARE THE FOLLOWING DOCUMENTS ATTACHED TO THE COST REPORT, IF APPLICABLE?
   - (a) WORKING TRIAL BALANCE AND SUPPORTING SCHEDULES USED TO PREPARE THE COST REPORT
   - (b) DEPRECIATION SCHEDULE
   - (c) CENTRAL OFFICE COSTS AND ALLOCATION SCHEDULES
   - (d) LOAN AGREEMENTS AND AMORTIZATION SCHEDULES (FOR LOANS OF $5,000 AND MORE)
   - (e) DISKETTE OF CENSUS SHEETS (AU-3902)
   - (f) DOCUMENTATION OR RESOLUTION STATING PERSON'S AUTHORITY TO SIGN DECLARATION STATEMENT IF NOT AN OWNER OR PARTNER
   - (g) WORK PAPER FOR THERAPY EXPENSE ADJUSTEMENTS
   - (h) COST ALLOCATION SCHEDULES FOR OTHER NON NURSING FACILITY PROGRAMS

DECLARATION OR PREPARER:

I COMPILED THE ACCOMPANYING COST REPORT, INCLUDING ACCOMPANYING SCHEDULES AND STATEMENTS PREPARED FOR . (PROVIDER NAME AND NUMBER) FOR THE COST REPORT PERIOD BEGINNING Jan 00, 1900 AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS TRUE, CORRECT, COMPLETE, AND IN AGREEMENT WITH RELATED BOOKS AND FEDERAL INCOME TAX RETURN EXCEPT AS EXPLAINED IN THE RECONCILIATION, THAT I HAVE REQUESTED ALL NECESSARY AND AVAILABLE MATERIAL AND THAT ALL MATERIAL TRANSACTIONS WITH OWNERS OR OTHER RELATED PARTIES HAVE BEEN SUMMARIZED ON APPROPRIATE SCHEDULES. I UNDERSTAND THAT THIS INFORMATION IS SUBMITTED FOR THE PURPOSE OF DEVELOPING PAYMENT RATES UNDER THE KANSAS MEDICAID PROGRAM. I UNDERSTAND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS, OR CONCEALMENT OF MATERIAL FACT MAY BE PROSECUTED UNDER APPLICABLE FEDERAL AND/OR STATE LAW.

PREPARER'S SIGNATURE	TITLE/POSITION	DATE

NAME (PRINT OF TYPE)

PREPARER'S ADDRESS (STREET, CITY, STATE, ZIP)	PHONE # FAX #

DECLARATION OF OWNER; PARTNER; OR OFFICER OF THE CORPORATION, CITY, OR COUNTY WHICH IS THE PROVIDER:

I HEREBY CERTIFY THAT I HAVE READ THE ACCOMPANYING COST REPORT, INCLUDING ACCOMPANYING SCHEDULES AND STATEMENTS AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS TRUE, CORRECT, COMPLETE, AND IN AGREEMENT WITH RELATED BOOKS AND FEDERAL INCOME TAX RETURN EXCEPT AS EXPLAINED IN THE RECONCILIATION THAT ALL MATERIAL TRANSACTIONS WITH OWNERS OR OTHER RELATED PARTIES HAVE BEEN SUMMARIZED ON APPROPRIATE SCHEDULES. I CERTIFY THAT NO MATERIAL OR INFORMATION I HAVE ACCESS TO WOULD PRODUCE FINDINGS CONTRARY TO THOSE IN THE ACCOMPANYING COST REPORT INCLUDING ACCOMPANYING SCHEDULES AND STATEMENTS. I UNDERSTAND THAT THIS INFORMATION IS SUBMITTED FOR THE PURPOSE OF DEVELOPING PAYMENT RATES UNDER THE KANSAS MEDICAID PROGRAM. I UNDERSTAND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS, OR CONCEALMENT OF MATERIAL FACT MAY BE PROSECUTED UNDER APPLICABLE FEDERAL AND/OR STATE LAW.

SIGNATURE AND TITLE OF OWNER, PARTNER, OR OFFICER OF THE CORPORATION, CITY OR COUNTY WHICH IS THE PROVIDER. IF PERSON SIGNING IS NOT AN OWNER OR PARTNER, PLEASE ATTACH DOCUMENTATION OR A RESOLUTION SHOWING THEIR AUTHORITY TO SIGN. (UNLESS ONE HAD BEEN PREVIOUSLY SENT AND ON FILE)

SIGNATURE	TITLE/POSITION	DATE

NAME (PRINT OR TYPE)

30-10-18. Rates of reimbursement. (a) Rates for existing nursing facilities.

(1) The determination of per diem rates shall be made, at least annually, on the basis of the cost information submitted by the provider and retained for cost auditing. The cost information for each provider shall be compared with other providers that are similar in size, scope of service, and other relevant factors to determine the allowable per diem cost.

(2) Per diem rates shall be limited by cost centers, except where there are special level of care facilities approved by the United States department of health and human services. The limits shall be determined by the median in each cost center plus a percentage of the median. The percentage factor applied to the median shall be determined by the secretary.

(A) The cost centers shall be as follows:

(i) Administration;

(ii) property;

(iii) room and board; and

(iv) health care.

(B) The property cost center limit shall consist of the plant operating costs and an adjustment for the real and personal property fees.

(C) The base health care cost center limit shall be calculated on the statewide average case mix index determined from the classified resident assessments, using the following criteria:

(i) The health care cost center limit for each facility shall be calculated by adjusting the base limit by that facility's average case mix.

(ii) Resident assessments that cannot be classified shall be assigned to the lowest case mix index.

(D) The percentile limits shall be determined from an annual array of the most recent historical costs of each provider in the data base.

(3) To establish a per diem rate for each provider, a factor for incentive and inflation shall be added to the allowable per diem cost.

(4) Resident days in the rate computation.

(A) Each provider that has been in operation for 12 months or longer and has an occupancy rate of less than 85 percent for the cost report period shall have the resident days calculated at the minimum occupancy of 85 percent.

(B) The 85 percent minimum occupancy rule shall be applied to the resident days and costs reported for the 13th month of operation and after. The 85 percent minimum occupancy requirement shall be applied to the interim rate of a new provider, unless the provider is allowed to file a projected cost report.

(C) The minimum occupancy rate shall be determined by multiplying the total number of licensed beds by 85 percent. In order to participate in the Kansas medical assistance program, each nursing facility provider shall obtain proper certification for all licensed beds.

(D) Each provider with an occupancy rate of 85 percent or greater shall have actual resident days for the cost report period used in the rate computation.

(5) Each provider shall be given a detailed listing of the computation of the rate determined for the provider's facility.

(6) The effective date of the rate for existing providers shall be in accordance with K.A.R. 30-10-19.

(b) Comparable service rate limitations.

(1) For each nursing facility and nursing facility for mental health, the per diem rate for care shall not exceed the rate charged for the same type of service to residents not under the Kansas medical assistance program. Private plan rates reported to the agency on other than a per diem basis shall be converted to a per diem equivalent.

(2) The agency shall maintain a registry of private pay per diem rates submitted by providers.

(A) Providers shall notify the agency of changes in the private pay rate and the effective date of that change so that the registry can be updated.

(i) Private pay rate information submitted with the cost reports shall not constitute notification and shall not be acceptable.

(ii) Providers may send private pay rate notices by certified mail so that there is documentation of receipt by the agency.

(B) The private pay rate registry shall be updated based on the notification from the providers.

(C) The effective date of the private pay rate in the registry shall be the later of the effective date of the private pay rate or the first day of the following month in which complete documentation of the private pay rate is received by the agency.

(i) If the private pay rate effective date is other than the first day of the month, the effective date in the registry shall be the first day of the closest month. If the effective date is after the 15th, the effective date in the register shall be the first day of the following month.

(ii) For new facilities or new providers coming into the medicaid program, the private pay rate effective date shall be the issued certification date.

(3) The average private pay rate for comparable services shall be included in the registry. The average private pay rate may consist of the following variables:

(A) Room rate differentials. The weighted average private pay rate for room differentials shall be determined as follows:

(i) Multiply the number of private pay residents in private rooms, semiprivate rooms, wards, and all other room types by the rate charged for each type of room. Sum the resulting products of each type of room. Divide the sum of the products by the total number of private pay residents in all rooms. The result, or quotient, is the weighted average private pay rate for room differentials.